Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BASSETT SURGERY CENTER
6211 EDGEMERE SUITE 2
EL PASO TX 79925

Respondent Name

EL PASO COUNTY

Carrier's Austin Representative Box
Box Number 42

MFDR Tracking Number
M4-11-4399-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Bilateral facet block injections were performed. Applying bilateral procedure rules, the reimbursement is 150% of the MAR for each level. Procedure code 64493 should be reimbursed at $955.83…and procedure 64494 should be $336.10."

Amount in Dispute: $540.89

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2011	ASC Services for Code 64493-SG-50	$317.00	$317.00
	ASC Services for Code 64494-SG-50	$223.89	$223.89
TOTAL		$540.89	$540.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 18, 2011

   - W1T-Workers compensation state fee schedule adjustment * Reimbursement per ASC guidelines Rule 134.402.
   - 59-Processed based on multiple or concurrent procedure rules.

   Explanation of benefits dated June 30, 2011

   - W1T-Workers compensation state fee schedule adjustment * Reimbursement per ASC guidelines Rule 134.402.

Issues

1. Did the respondent support position that additional reimbursement is due for code 64493-SG-50?
2. Did the respondent support position that additional reimbursement is due for code 64494-SG-50?

Findings

1. The respondent denied reimbursement for code 64493-SG 50 based upon "W1T-Workers compensation state fee schedule adjustment * Reimbursement per ASC guidelines Rule 134.402".

   HCPCS code 64493 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level".

   The February 24, 2011 Operative report indicates that the requestor underwent bilateral facet injections at L4-5 and L5-S1.

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

   The MAR for HCPCS code 64493-SG-50 is ($271.58 X 235%) X 150% = $957.31. The respondent paid $638.21. The difference between the MAR and amount paid is $319.10. The requestor is seeking medical dispute resolution for $317.00 for this code; this amount is recommended for additional reimbursement.

2. HCPCS code 64494 is defined as "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)".

   The MAR for HCPCS code 64494-SG-50 is ($95.50 X 235%) X 150% = $336.63. The respondent paid $112.21. The difference between the MAR and amount paid is $224.42. The requestor is seeking medical dispute resolution for $223.89 for this code; this amount is recommended for additional reimbursement.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor has supported its position that reimbursement is due. As a result, the amount ordered is $540.89.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $540.89 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		4/20/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.